

COMPREHENSIVE HIV PLAN

SUMMARY OF PRIORITIES AND NEEDS ASSESSMENT FINDINGS

Developed by the
Long Beach Comprehensive HIV Planning Group

April 10, 2000

INTRODUCTION

The Comprehensive HIV Plan for Long Beach (HIV Plan) is intended to help increase the effectiveness of HIV care and prevention providers and funders. It establishes a framework to coordinate HIV care and prevention activities, focusing efforts on effective interventions for the populations most at-risk for HIV infection and on priority needs for HIV affected individuals. This summary highlights aspects of the HIV Plan that directly affect providers, and is offered to assist providers as they start new or continue ongoing HIV services. Details about the planning process and important supporting information will be included within the full HIV Plan document.

LONG BEACH COMPREHENSIVE HIV PLANNING GROUP

The Long Beach Comprehensive HIV Plan represents the outcome of an important and ongoing community planning process that began in January 1999. The initiative is part of a community-based approach to comprehensive HIV planning. During the last year, the Long Beach Comprehensive HIV Planning Group (Planning Group) has become a diverse and informed planning body. It has developed procedures, collected data, and undertaken an intensive planning process.

The Planning Group is the result of a January 1999 merger of the existing Long Beach HIV CARE Consortium and the Long Beach HIV Prevention Community Planning Committee. This process included expanding the original membership, developing new roles and responsibilities and electing community co-chairs. The Planning Group exists to provide collaborative HIV care and prevention planning for the City of Long Beach.

Membership of the Planning Group was expanded in an effort to be broadly representative of the community involved in HIV care and prevention and to reflect the characteristics of the current HIV/AIDS epidemic in Long Beach. The Planning Group includes representatives from HIV care and prevention providers, as well as organizations serving the related needs of those most at risk. It includes members from the racial, ethnic and sexual minority communities of Long Beach. The Planning Group has members who are self-identified HIV positive. The Planning Group is led by three co-chairs. Two community co-chairs were elected by the planning body and one co-chair was designated by the Health Department. Finally, ongoing community input was obtained through regular opportunities for public comment at all Planning Group meetings.

Immediately upon formation, the Planning Group was faced with the formidable task of developing a comprehensive HIV plan for Long Beach; this plan updates and combines the existing care and prevention plans. To facilitate and inform this process the City of Long Beach Department of Health and Human Services (Health Department), in consultation with the Planning Group, hired two researchers, Gail Farmer, Dr.P.H. and Carole Campbell, Ph.D., from the California State University, Long Beach. Dr. Farmer and Dr. Campbell began working with the Planning Group in June 1999. Under the guidance of the Planning Group, the researchers provided technical support and conducted primary research to inform the process. This needs assessment process included interviews of HIV care and prevention providers, focus groups with members of at-risk populations, and surveys of HIV-infected individuals. The researchers also participated in planning meetings and assisted in the facilitation of a day-long retreat.

PRIORITIES FOR PREVENTION SERVICES

After a thorough review of the sociodemographic, behavioral and epidemiological indicators and co-factors of HIV risk, the Planning Group identified four priority populations for prevention services. Long Beach prevention efforts should emphasize these populations and relevant co-factors and indicators when appropriate. As further guidance, the Planning Group passed the following resolution related to efforts targeting the priority populations.

The Long Beach Comprehensive HIV Planning Group strongly believes that people of color, people living in poverty, and youth, age 30 and younger, have less access to, or experience more barriers to accessing, services and resources, and therefore believes that these populations should be emphasized within each priority category when appropriate.

- Approved October 20, 1999

Men Who Have Sex With Men (MSM)

Definition: All men who have sex with men. Includes self-identified gay or bisexual men as well as men who have, or have had, male-to-male sex but identify as heterosexual.

Rationale: Based on a review of HIV and AIDS seroprevalence data, unprotected male-to-male sex continues to be the primary mode of HIV transmission in Long Beach.

Indicators/Cofactors:

- Substance misuse
- Multiple partners
- Sex for drugs, money or survival
- Sexually transmitted disease (STD)

Drug Users

Definition: Individuals who misuse drugs of any type including injected drugs, non-injected drugs and alcohol.

Rationale: Sharing unsterilized needles and equipment during injection drug use is the second most prevalent HIV transmission mode in Long Beach. HIV seroprevalence data suggest that substance misuse of any kind may predict unsafe sexual behaviors or needle sharing.

Indicators/Cofactors:

- Sex for drugs, money or survival
- Multiple drug and/or sex partners

High-Risk HIV Positive Individuals

Definition: Individuals who are aware of their positive HIV status and still engage in unsafe behaviors, including sharing needles and equipment and/or having unprotected sex.

Rationale: Data suggest that individuals who are aware of their HIV positive status who continue to engage in high risk behaviors compromise their own health and place others at risk for HIV.

Indicators/Cofactors:

- Substance misuse
- Sex for money, drugs or survival
- Multiple drug and/or sex partners

High-Risk Women

Definition: Women who engage in unsafe sex or drug practices, or women who have a sex or drug use partner at risk.

Rationale: Data suggest that women who engage in high-risk behaviors or have partners who engage in high-risk behaviors, place themselves and others at risk for HIV.

Indicators/Cofactors:

- Substance misuse
- Sex for money, drugs or survival
- Multiple drug and/or partners
- STD
- Post-incarcerated partners
- MSM partner
- Victims of sexual or physical abuse
- Lack of healthcare utilization

CHOOSING APPROPRIATE AND EFFECTIVE HIV PREVENTION INTERVENTIONS

The Planning Group developed the following value statements as guidelines to assist providers in selecting the most effective and appropriate interventions. The Planning Group believes that all HIV prevention programs should embody these values.

HIV prevention programs will:

- Have explicit goals and measurable objectives that relate to, and support, the broader goals and objectives set forth in this comprehensive plan;
- Develop and implement a program evaluation that relates to the project's goals and objectives;
- Be client-centered – representatives of the targeted population will participate in the development, implementation and evaluation of the intervention;
- Be culturally sensitive, linguistically appropriate, and literacy-level specific;
- Have demonstrated empirical support or be consistent with a sound theoretical approach to behavior change;

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- Make available directly or through collaboration the tools necessary to prevent HIV transmission, such as condoms, bleach or sterile injection equipment; and,
 - Include components that help maintain change and provide positive reinforcement to individuals for their successful behavior change.

Sample Strategies and Interventions

The Planning Group identified the following sample strategies and interventions to serve as additional guidance to assist prevention providers in selecting appropriate and effective strategies.

MSM

1. Peer-based programs – particularly individual, group-level counseling and community-level outreach (for all men who have sex with men)
2. Interventions that change community norms and reinforce successful behavior change
3. Condom/Lubrication distribution
4. Risk reduction counseling

Drug Users

1. Needle and syringe exchange
2. Peer-led strategies including skill building, condom and bleach distribution, and street and community outreach
3. Risk reduction counseling

High-Risk HIV Positive

1. Prevention case management
2. Peer-led strategies including skills building, condom and bleach distribution, and street and community outreach
3. Risk reduction counseling

High-Risk Women

1. Risk reduction counseling, including skills building, behavioral interventions and education – specifically, individual and/or group-level peer/professional counseling
2. Mass media/public interventions that increase awareness among women

PRIORITY NEEDS FOR HIV CARE SERVICES

After a thorough review of the needs assessment data from individuals and agencies, sociodemographic and epidemiological indicators of HIV/AIDS, and other relevant secondary data, the Planning Group identified three high priority service areas (see table on following page. No one category is prioritized over another; however, the services within each category are prioritized.

LINKAGES AND COORDINATION BETWEEN CARE AND PREVENTION SERVICES

The Planning Group identified opportunities for linkages and coordination between care and prevention service providers. The following recommendations were made:

PRIORITY NEEDS FOR HIV CARE SERVICES		
Category One – Health Care	Category Two – Case Management	Category Three – Basic Needs
Primary Care Substance Abuse Mental Health Specialty Care Treatment Advocacy Medications Nutrition	Case Management Benefits Financial Assistance Vocational Rehab Legal Advice Support Group Self Help Life Skills	Housing <ul style="list-style-type: none"> • Emergency • Transitional • Permanent Food Transportation

- Maintain a forum for HIV care and prevention providers to discuss linkages through representation and participation on the Planning Group. Additionally, agendas should include an opportunity for providers to discuss the development of creative approaches to service delivery that link HIV care and prevention services.
- Providers should establish formal relationships and procedures for referring newly diagnosed HIV positive individuals into HIV care services.
- Partner Counseling and Referral Services (PCRS) should be utilized to notify and engage partners of HIV positive individuals to receive appropriate testing, diagnosis and treatment.
- Web-based technology should be used to improve the maintenance and use of community resource directories.
- Create stronger linkages between HIV prevention providers and care providers to improve care and prevention services for discordant couples.
- Increase awareness of influence of environmental issues such as homelessness, substance use and mental health on an individual.
- Encourage providers to incorporate the use of HIV positive individuals as educators among the HIV negative individuals within their personal network.
- Increase educational opportunities for health care workers to help improve the provision of high quality services to HIV positive individuals and to improve HIV prevention services in non-HIV medical settings.
- Improve awareness of available HIV care services among HIV prevention providers.
- Increase the availability of HIV care and prevention services in the jail setting.
- Increase awareness among HIV care and prevention providers about cultural appropriateness and influence on the provision of services.
- Integrate HIV prevention services with drug rehabilitation services, hospitals and other care services.

NEEDS ASSESSMENT ACTIVITIES AND FINDINGS

The purpose of this research was to provide a comprehensive framework for systematically assessing the need for HIV/AIDS treatment and prevention services in the City of Long Beach. A research team was formed to conduct a needs assessment. This team was composed of members from the Planning Group, and faculty from California State University, Long Beach. The findings from this research provided the basis for strategic planning. The objectives of this needs assessment were fivefold:

- 1) To determine the barriers to HIV/AIDS treatment and prevention services and the unmet needs of persons with HIV who reside in the City of Long Beach;
- 2) To identify and focus attention on populations of HIV infected individuals (women and race-ethnic minorities) who have historically been unserved and/or underserved by both public and private agencies;
- 3) To ascertain the current perceptions of persons with HIV regarding the identity and function of public and private agencies providing treatment and prevention services;
- 4) To identify the range of potential interventions that may be effective in meeting the needs of persons with HIV; and
- 5) To ascertain current knowledge, attitudes, and behaviors concerned with preventing the transmission of the HIV by (a) infected persons and (b) non-infected persons.

Several data collection methodologies were utilized to accomplish these objectives. One method was a field survey to determine the self-reported needs of persons infected with HIV. A second method consisted of in-depth interviews conducted with personnel from HIV related services and organizations to examine the major issues challenging the providers of service. Finally, a third method utilized a series of focus groups with non-HIV infected persons to ascertain their knowledge, attitudes and behaviors associated with preventing the transmission of the disease. Additionally, a review and analysis of epidemiological, behavioral and other secondary data resources, as well as a literature review of prevention strategies and interventions was conducted.

Three target populations were identified to provide a comprehensive body of information to assess the need for HIV/AIDS treatment and prevention services. One population consisted of persons infected with HIV who received services in Long Beach or resided in the City. A second population was the providers of HIV related services within the City of Long Beach and the surrounding area. Finally, the third population constituted persons not infected with HIV residing within the City of Long Beach.

EPIDEMIOLOGICAL PROFILE

Introduction

Comprising 50 square miles at the southernmost end of Los Angeles County, Long Beach has approximately a half-million residents, making it the fifth largest city in California and the 32nd largest in the United States. One of only three city-based health departments in California, the City of Long Beach has maintained the Health Department for over 90 years.

Its size, diversity and geographic location in a major population center have made Long Beach particularly vulnerable to HIV and AIDS. With a cumulative rate of 803 AIDS cases per 100,000 residents (for cases reported through December 1998), Long Beach's AIDS incidence rate per capita is second only to San Francisco among the state's 61 local health jurisdictions, exceeding that of Los Angeles County.

Demographic Overview

A number of demographic indicators have been associated with increased incidence of HIV infection. Men who have sex with men continue to represent the largest sector of HIV-infected Americans. Injection and non-injection drug users, sexually active adolescents (defined as 13 to 18 years old), people of color and the economically disadvantaged are among groups increasingly enduring the epidemic to a disproportionate degree. Examining these particular demographic and behavioral indicators will help provide a better understanding and clearer context of the HIV/AIDS epidemic in Long Beach.

Age

A full quarter of Long Beach's population is under the age of 18, and 21 percent of the population is age 13 or younger. Another 13 percent is between 18 and 24 years old. Thirty-six percent of the population is between the ages of 25 and 44, and another quarter of the population is over the age of 44. These proportions are very similar to the age breakdown of California overall (Source: U.S. Census, 1990).

Race and Ethnicity

People of color presently comprise at least 43 percent of California's population. By the year 2000, the proportion of African Americans, Latino/Hispanics, Asian/Pacific Islanders and Native Americans combined will exceed 50 percent of the population (U.S. Census, 1990). More than 38 percent of the state's AIDS cases occur within ethnic communities (Source: California AIDS Case Registry). The implications for the HIV epidemic vary among the populations, but in general, cultural and linguistic barriers have limited the success of prevention interventions.

Like California, Long Beach has a population that is ethnically and racially diverse. More than half of the population of Long Beach, in fact, consists of people of color. The next largest ethnic group, comprising almost a quarter of the city's population, is Latino/Hispanic. African Americans and Asians/Pacific Islanders each represent about 13 percent of the population. The remaining portion of Long Beach residents is Native Americans and persons of other or mixed racial heritage. These groups are relatively small in number, comprising less than one percent of the city's population (U.S. Census, 1990).

Poverty

Epidemiological trends have shown that new infections are increasing among people living below the poverty line. In California, young people, women and people of color have incomes below the poverty line more often than other populations – 18 percent of young people, 12 percent of women and 20 percent of people of color (U.S. Census, 1990). A general vulnerability common to poorer people can enhance their risk to engage in specific risk behaviors and significant co-factors, including drug use (injection and non-injection) and survival sex.

In Long Beach, people of color are poorer on average than the white population. Overall, the proportion of Long Beach residents living in poverty is greater than in Los Angeles County or California.

AIDS Surveillance Data

The California Code of Regulations, Title 17, Section 2500 requires that all diagnosed or suspected cases of AIDS as defined by the CDC must be reported within seven days to the local Health Officer. To facilitate reporting, the Health Department maintains an AIDS surveillance unit (funded by the State of California Department of Health Services Office of AIDS) with staff trained in AIDS surveillance techniques. The AIDS surveillance unit disseminates data through the monthly *Public Health Bulletin*, the semi-annual *HIV/AIDS Monitoring Report*, and through responses to data requests from the community.

Cumulative Cases

As of December 31, 1998, there was a cumulative total of 3,447 AIDS cases in Long Beach. The cumulative case fatality rate of 62 percent is the same as California and slightly lower than Los Angeles County (63 percent). Of the 3,447 reported AIDS cases in Long Beach, approximately 1,322 people are currently living. The cumulative incidence of AIDS in Long Beach is the second highest in the state when compared to other health jurisdictions. At 803 cases per 100,000 residents (for reported cases through 1998), the rate is more than twice that of California overall, and over 80 percent higher than that of Los Angeles County.

Race/Ethnicity

Of the cumulative AIDS cases, approximately 65% are white. While whites still comprise the majority of AIDS cases, this appears to be changing. When the year 1998 is examined in isolation, 43 percent of all cases for that year were among Whites. The proportion of AIDS cases represented by African Americans rose to 28 percent of new cases in 1998 compared to 16.5 percent of cumulative cases. Similarly, 1998 recognized an increase in the percentage of AIDS cases among Hispanics. In 1998, 26 percent of AIDS cases were diagnosed among Hispanics, a disproportionate amount when compared to their population of 23.6 percent of the Long Beach population. The number of AIDS cases diagnosed among the Asian/Pacific Islander population has remained consistent over the past several years.

Gender

The vast majority of AIDS cases in Long Beach are male (for cases reported through December 1998). Only 5 percent of the cumulative AIDS cases are female. Females do comprise a higher proportion of the new cases in 1998 (9.8 percent) suggesting that more women may be becoming infected. Among men, transmission of HIV has primarily occurred from male-to-male sexual activity.

Age

Through December 1998, close to half of the cumulative AIDS cases in Long Beach were diagnosed among people between the ages of 30 and 39. One-quarter of all cases were diagnosed among people in their 40s. This indicates that the majority of people with AIDS in Long Beach were infected in young adulthood. Sixteen percent of AIDS cases, however, were

diagnosed in people in their twenties, suggesting that a significant number of people with AIDS became infected during adolescence.

Behavior/Risk Categories

Eighty-one percent of all male AIDS cases in Long Beach reported male to male sexual risk behavior (for cases reported through December 1998). An additional 8.5 percent reported both male to male sexual behavior and injection drug use. Nearly seven percent of male AIDS cases reported injection drug use as the sole risk behavior. One percent of male AIDS cases were infected through heterosexual sexual behavior.

Among women, however, heterosexual behavior and injection drug use are much more prevalent modes of HIV transmission. Of female AIDS cases in Long Beach, 47 percent were infected through heterosexual contact. Another 40 percent were infected through injection drug use. Six percent were infected through transfusions, while for the remaining 7 percent the risk was unknown or pending investigation.

HIV Data

This section considers HIV-specific data reported by specific testing sites or special surveillance studies. These data reflect HIV seroprevalence of a specific population and are not generalizable beyond that population. They nonetheless give seropositivity rates for groups that are generally at higher risk: people who test at the City's Alternative Test Site, Sexually Transmitted Disease Clinic patients, drug users and men who have sex with men. These data are also distinct from AIDS-specific data. AIDS data are retrospective: they reflect persons who have advanced HIV disease. Although interesting, they are not the same as HIV-specific data because they cannot consider people who are HIV-positive and asymptomatic or people who are HIV-positive who have not presented illnesses or T-cell counts that meet the AIDS case definition set by the CDC. Moreover, in Long Beach, AIDS data are for the entire city, while other data reflect specific sub-populations. Thus, this information provides guidance rather than conclusive fact.

HIV Alternative Test Site Data

Alternative Test Sites are anonymous HIV testing sites that are state-mandated alternatives to Federal/CDC-funded testing sites, and to confidential test sites. Long Beach has two Alternative Test Sites: one at the Health Department and one at the Gay and Lesbian Community Center of Greater Long Beach. Analysis of antibody test results from Alternative Test Sites (ATS) in Long Beach show dramatic declines in the HIV seropositivity rate since 1985, when the test first became available. Positivity rates fell most dramatically between 1985 and 1987. Since 1992, positivity rates have fluctuated between 1.8 and 2.6 percent. One limitation of ATS data, however, is that they report tests performed, not unduplicated clients.

A comparison of reported AIDS cases to HIV-positive tests at Alternative Test Sites by race/ethnicity shows some interesting differences. The proportion of whites who test positive at an ATS is 6 percent less than the proportion of whites who have AIDS. The proportion of African Americans among those testing positive is about 2 percent less than reported AIDS cases. In contrast, the proportion of Hispanics and Asians who test positive is greater than the proportion of those groups among reported AIDS cases. These differences possibly indicate the shifting demographic profile of the epidemic, as AIDS rates continue to increase among

people of color. Race and ethnicity might also explain these differences. Whites, for example, may have greater access to private health care and choose not to test at an ATS.

Similar differences are seen in comparisons of reported AIDS cases and HIV positivity at ATS by age. The proportion of 20 to 29 year olds who test positive is over twice their proportion among reported AIDS cases. The proportion of older groups who test positive is significantly less than their proportion of reported AIDS cases. While lack of access to private health care for younger adults may be part of the explanation, it is more likely that the lag time between seroconversion and the development of AIDS-related conditions accounts for the differences. People frequently become infected in their twenties, but are not diagnosed with AIDS until they are several years older.

SURVEY OF PERSONS INFECTED WITH HIV

Research Design

The population of the field survey represented persons infected with HIV who resided in the City of Long Beach or received services in the City. The research protocol included the following activities: (a) develop the questionnaire; (b) pilot test and revise the questionnaire; (c) obtain the human subjects protection clearance; (d) develop the sampling frames, identify clusters, and select the sample; (e) train the interviewers; (e) implement the field survey; (f) code the data, and construct a computer file; and (g) perform the data analysis and interpret the findings.

The structured data collection instrument (a questionnaire) examined need, service utilization and barriers to care, risk-taking behavior, and preventive health behavior among persons infected with HIV. There were six areas of need appraised: (1) health (i.e., physical, mental and dental), (2) education, (3) housing, (4) transportation, (5) employment, and (6) legal issues.

The instrument consisted of approximately 87 questions. The content, wording and placement of the questionnaire items were derived and evaluated by members of the Planning Group, faculty from California State University at Long Beach, leaders from community-based organizations, and providers of health care. The instrument had passed through approximately six substantial revisions and University human subjects' review.

Many of the questions were open-ended utilizing extensive probes by the interviewer. This was to enhance the cultural appropriateness of the questions as well as to reduce the potential of leading the respondent into limited, preconceived types of responses. Validity and reliability evaluations were performed for the coding and data entry. This technique yielded a broad spectrum of valuable information.

In order to minimize a literacy bias and maximize anonymity, the interviewer read the questions aloud while the respondent followed along on a separate instrument and recorded the answers on their instrument. To insure anonymity, each respondent deposited the completed instrument into a closed box through an open slit. The interviewer reading the questions was situated so they could not observe the respondent's answers. Thus, the method of data collection was a modified interview. Each questionnaire took approximately 30 to 45 minutes to complete. The consent form and questionnaire were translated into Spanish.

Two different sampling methods were used to select the field survey participants. One method used a stratified, multistage cluster procedure and the other applied a peer referral strategy. With the stratified, multistage cluster procedure, the clusters were identified and chosen by the research team. The clusters were selected which had a high proportion of HIV-infected persons within them. The clusters were then stratified on the following characteristics of the persons with HIV: the stage of HIV infection and level of functioning as well as age, gender, sexual preference, race-ethnicity, and socioeconomic status.

Access to people infected with HIV in Long Beach was gained in two phases. First, a directory was compiled identifying names, addresses and telephone numbers of churches, alcohol rehabilitation programs, community support groups, family services, medical centers (public and private), gay and lesbian organizations, and recreational programs. Every effort was made to provide a full spectrum of socioeconomic status, age cohorts, and health status. Second, to establish rapport and promote knowledge of the field survey the research team sent letters, made follow-up telephone calls, and personal visits to the sites selected for fielding the needs assessment survey.

Thus persons infected with the HIV were located from the following clusters within the City of Long Beach: government agencies, public and private hospitals, community-based organizations, places of worship, food banks, and bars. Representatives from these organizations were asked to publicize the needs assessment field survey and to allocate a space for the administration of the questionnaire that would maximized privacy.

The strength of the stratified sampling procedure was its ability to promote a representative sample and thereby increase the generalizability of the findings to the larger population of HIV infected persons needing services. The chief disadvantage of cluster sampling was the lack of randomization. This made it impossible to calculate the probability of including or excluding respondents in the sample. However, because it was not possible to enumerate all persons who are identified as HIV positive for random assignment, the cluster sampling method provided the best alternative given the purpose of the research.

While persons with HIV were at the various clusters, an interviewer approached each person and asked a series of questions to determine their eligibility to participate in the field survey. The screening questions determined if they were HIV positive, at least 18 years of age, and had not previously responded to this survey. If a person was eligible, they were invited to participate in the survey. Persons who were interested in participating were guided to a separated area (to assure privacy) where the contents of the consent form were discussed and the questionnaire was administered.

The second method of sampling for the field survey was peer referral. Those persons infected with HIV who were selected by the cluster sampling were asked to recommend the field survey to other persons infected with HIV and provide these individuals with a telephone number to contact a member of the research team at California State University, Long Beach. When the potential respondent called the research unit, he/she was asked a set of screening questions to determine their eligibility to participate in the survey. The screening questions assessed if they were HIV positive, at least 18 years of age, and had not previously responded to this survey. A person was designated as eligible to participate in the survey, if an affirmative response was given to all three questions. For those who were eligible, the interviewer arranged an appointment to meet with the individual at a convenient location to administer the questionnaire. The peer referral procedure was particularly useful for identifying HIV infected

individuals who may have been socially or physically isolated.

The chief advantage of the field survey method was the identification of unmet treatment and prevention service needs of HIV infected persons throughout the City of Long Beach. For example, the data included HIV infected persons who have accessed services as well as those who have not. In addition, this method utilized sampling procedures which enable the findings to be generalized to the broader HIV infected population and their needs.

There were a number of potential problems associated with the field survey method which were taken into account in this research. First, the refusal rate was minimized through the allocation of \$10 grocery certificates to participants who completed the questionnaire. Second, recall and truthfulness were fostered by the wording and the order of the questions in the instrument as well as the training of the interviewers.

Interviewers were trained in the methods which promote the reliability and the validity of data collection. Interviewers received a three-day comprehensive training seminar in data collection methods and procedures. The elements of the training seminar consisted of (a) the purpose of the needs assessment; (b) survey research as a method of research; (c) interview procedures, such as initial contact, securing the interview, commitment to scheduled appointments, interview locations and situations, number of interviews to be conducted, length of interview contact; (d) methods to gain respondents' trust by establishing rapport; (e) familiarization of the questionnaire used in the interview; (f) ethics of survey research; and (g) debriefing process with staff.

The methods for analyzing the assessment data utilized two approaches. One approach involved processing and analyzing the quantitative data collected from the field survey, including transforming assessment items into numerical codes; entering data into a computer file with validity checks; constructing a computer systems file using the Statistical Package for the Social Sciences (SPSS); and performing univariate and bivariate analyses. The second approach relied on standard qualitative methods based on content analyses for describing the findings for open-ended questions.

Findings from the Field Survey

The field survey was implemented from July 1999 to September 1999. The targeted number of completed interviews was exceeded by 29. The number of completed interviews was 279. Approximately 11 percent of the persons who were asked to participate in the needs assessment declined the invitation. The considerable effort placed on social networking by the research team resulted in widespread and enthusiastic cooperation by the community.

Demographic Profile

The demographic profile of the 279 persons who participated in the field survey was as follows. The median age was 38 years with a range from 18 to 69 years. The race/ethnic distribution was African-American (21%), American Indian/Alaskan (2%), Asian and Pacific Islander (2%), Latino/Hispanic (20%), White/Caucasian (54%), and Other (1%) (Table 1). English and Spanish were the two languages reported and Spanish was the primary language for about 10 percent of the sample (Table 2). Eighty-three percent were male, 17% were female, and .4% identified as transgender (Table 3). For this sample, the women were more likely to come from the African-American and the Hispanic racial-ethnic groups, while the men were more likely to

be White.

The distribution of sexual preference was gay/lesbian (64%), bisexual (8%), and straight/heterosexual (28%) (Table 4). The median level of formal education was high school graduate with 25 percent reporting a college degree (associate, bachelors, graduate) (Table 5). The median annual income was approximately \$6,000 with 6 percent reporting incomes greater than \$20,000 (Table 6). The major sources of income were SSI (43%), SSDI (35%), and unemployment (35%) (Table 7). Fifty-six percent reported never being married, 13 percent were members of an unmarried couple, 17 percent were divorced, 5 percent were married, 5 percent were widowed, and 4 percent were separated (Table 8).

HIV Related Issues

When asked about the status of their HIV infection, 25 percent were infected before March 1988, and 25 percent reported being infected after January 1994. The vast majority (75%) was infected through unprotected sex (Table 9). Women were more likely to be infected through shared needles. As for their current HIV status, 35 percent were asymptomatic, 28 percent were symptomatic, and 37 percent had AIDS (Table 10). There were no significant differences in current HIV status relative to gender or race-ethnicity. The length of time at their current stage of diagnosis varied from zero months to 18 years with the median being 15 months.

Ninety-six percent reported that their medications were financed through some form of insurance (Table 11). Nineteen percent encountered barriers in accessing medications (Table 12). Of those reporting barriers, the major problem concerned keeping current on new drug therapies. While 14 percent reported that drug side effects were severe, 39 percent had experienced moderate side effects, and 47 percent reported that their side effects were minimal (Table 13). The majority (60%) reported that the medications made their health condition better, while 28 percent reported their health about the same and 12 percent felt their health condition was made worse by the medications (Table 14). There were no significant differences related to gender and race-ethnicity.

Physical Health Needs

When asked questions pertaining to their physical health status, 43 percent reported that they experience chronic health problems (Table 15). Of those with chronic health problems, 42 percent reported that the chronic conditions were related to the HIV infection (Table 16). Over half of the total sample, 51 percent, reported having physical health problems that needed attention (Table 17). Nearly 35 percent of those with physical health problems reported not receiving the needed care (Table 18). Women were significantly more likely to get the needed care than men. The major reasons cited for not obtaining needed care among men and women were no transportation, not knowing where to go for help, long wait for approval, and not being covered by insurance. Approximately one-third attributed the lack of care to their HIV positive status (Table 19).

Ninety-five percent of the respondents reported usually going to the same doctor or clinic for care (Table 20). Where they usually sought help for physical health problems were a physician (64%), emergency room (27%), hospital outpatients (29%), family/friends (10%), a chiropractor (4%), acupuncturist (2%), or an herbalist (.7%) (Table 21). The median number of physician visits during the previous six months was five, with a range from one to 50 visits. Medi-Cal (32%) and Medi-Cal/Medicare (34%) were the types of health insurance that the majority of

respondents reported (Table 22).

Only 17 percent of the respondents reported having problems with their health care provider (Table 23). The main complaint of those reporting problems with their health care provider concerned the long waiting time to get an appointment. Ninety percent of the respondents were either very satisfied or satisfied with their health care provider relative to the treatment received for the HIV infection (Table 24). Similarly, 89 percent reported being very satisfied or satisfied with the medical care received for non-HIV related problems (Table 25). The main problem reported was the difficulty in getting an appointment. However, 67 percent of the respondents felt that the doctors and medical staff should be better trained to care for persons with HIV infection (Table 26). This finding was consistent across race-ethnicity and gender. Of those respondents who provided suggestions for improvement, the majority wanted the doctors and medical staff to listen to them, exhibit more compassion, and employ more bilingual staff. In addition, a need for more studies on women with HIV was reported by the female respondents.

Approximately 36 percent of the respondents received care in a hospital within the past 12 months (Table 27). While it was not statistically significant, African-Americans were more likely to have received care in a hospital than other race-ethnic groups. Of those who received hospital care, 50 percent were inpatients and 50 percent were seen on an outpatient basis (Table 28). Only 13 percent of those respondents receiving care in a hospital setting experienced barriers due to their HIV status (Table 29). The major barriers depicted by the respondents were feelings of being ignored by the medical personnel, the staff showing fear of AIDS, and not receiving their medications in a timely manner.

When asked to rate their physical health, 10 percent of the respondents reported excellent, 52 percent reported good, 32 percent reported fair, and 6 percent reported poor (Table 30). Thus, almost two-thirds of the sample evaluated their health as good or excellent. Twenty-eight percent reported that their physical health was better now than it was a year ago (Table 31). Fifty-four percent felt their physical health was better than other persons with HIV (Table 32). Compared to the general population, about one-fourth of the respondents felt that their physical health was worse, 25 percent reported that their physical health was better, and 50 percent felt that their physical health was about the same as the general population (Table 33). Upon examining possible race/ethnic differences with respect to the self assessment of physical health status, it was found that Latinos/Hispanics were more likely than other groups to rate their health as excellent ($p=.005$), better now than a year ago ($p=.02$), better than other with HIV ($p=.02$), and better than the general public ($p=.01$). It should be noted that the reported differences across the different race/ethnic groups may reflect a cultural response-set bias. There were not significant differences among men and women with respect the self-assessments of health.

Activities of Daily Living

Seven activities of daily living were examined. It was found that the respondents needed help with the following activities: getting dressed (6%), bathing (62%), getting into bed (8%), toileting and hygiene (8%), preparing meals (23%), household chores (33%), and shopping/errands (25%) (Table 34). Of those respondents who reported needing help with activities of daily living, at least 40 percent of the respondents were not getting help with getting dressed, bathing, toileting and hygiene, preparing meals, household chores, and shopping/errands.

Psychological Health Needs

Responses to a series of questions regarding psychological health revealed the following data. Forty-nine percent reported needing help with psychological problems. The same percentage (49%) reported being assessed as needing psychological help. Whites and African Americans were significantly more likely to report being assessed as needing help with psychological problems than Latinos/Hispanics ($p=.03$) (Table 35). Only a third (34%) was getting the needed help with psychological or emotional problems (Table 36). Forty-seven percent rated their psychological health as fair or poor (Table 37). Sixty-one percent reported that their psychological health was worse or about the same compared to a year ago (Table 38). Compared to others with HIV, 58 percent rated their psychological health as being worse or about the same (Table 39). Twenty-seven percent rated their psychological health as being worse than that of the general population (Table 40). These findings were consistent across race/ethnic groups and gender.

A lack of insurance coverage for mental health conditions was reported by 57 percent of the respondents (Table 41). During the previous six months, the median number of times that a respondent who needed help with psychological problems received assistance was six with a range from 1 to 100. The major reasons for not obtaining needed help with psychological problems were difficulty getting an appointment, did not know where to go, and felt uncomfortable. Forty-six percent also reported that their HIV status was a factor for them not getting help with psychological problems (Table 42). When asked about where help is usually obtained with psychological problems the following sources were mentioned: counselors (37%), psychiatrists (27%), a family member (19%), friends (35%), clergy (6%), and peer groups (23%) (Table 43).

Thirty-nine percent reported that they usually go to the same source for psychological help (Table 44). While Latinos/Hispanics reported going to the same source for psychological help, African Americans and Whites reported not doing so ($p=.03$). The vast majority, 83 percent, expressed satisfaction with their source of psychological help (Table 45). However, 53 percent believe that providers of psychological health care should be better educated to help persons with HIV (Table 46). Additional suggestions offered by the respondents to providers of psychological health care were to exhibit more understanding/compassion toward a person with HIV, and provide answers to their questions.

Fifty-six percent of the respondents reported needing help with substance abuse problems (Table 47). There was no significant difference found among race-ethnic groups or by gender with respect to needing help with substance abuse. Of those reporting problems, the following types of substance abuse were mentioned: alcohol (37%), speed (37%), cocaine (15 %), marijuana (4%), psychedelic (4%), and heroine (4%). Approximately 44 percent reported seeking treatment for substance abuse problems (Table 48). Of those who have sought treatment, 50 percent reported participating in a drug rehabilitation program (Table 49). Eighty-two percent expressed satisfaction with the substance abuse program in which they participated (Table 50). The suggestion most offered by the respondents to improve the effectiveness of substance abuse rehabilitation programs was to reduce the prejudice towards persons with HIV.

Dental Health Needs

When asked about their dental health, 38 percent reported having problems with teeth or gums

(Table 51). Fifty-six percent reported not receiving help with their dental problems (Table 52). The reasons for not obtaining dental health care offered by a majority of the respondents concerned a lack of insurance coverage and their HIV status (Table 53 and 54). Thirty-seven percent reported a regular source of dental care (Table 55). The median number of dental visits reported during the past six months was 6, with a range from one to 20 visits. Only twenty-one percent expressed dissatisfaction with providers of dental health care (Table 56). Reasons for the dissatisfaction were lack of insurance and difficulty in getting an appointment. Fifty-four percent reported that providers of dental care need to be better trained to treat persons with HIV (Table 57). Suggestions for improvement offered by the respondents were: show more compassion to patients and more AIDS education for staff.

When asked to rate their dental health, 52 percent reported it being fair or poor (Table 58). Comparing their dental health to a year ago, nearly 25 percent reported their dental health was worse (Table 59). Compared to other persons with HIV, the following was reported: worse (13%), about the same (59%), and better (28%) (Table 60). Comparing themselves to the general population, 27 percent reported that their dental health was worse, and 49 percent reported their dental health was about the same (Table 61).

Housing Needs

The distribution of housing types of the respondents was as follows: 43 percent lived alone, 22 percent resided with significant other/partner, 7 percent resided with significant other and children, less than one percent lived with a spouse, and 6 percent reside with unrelated persons (i.e., renters, roommates) (Table 63). Forty-three percent reported having children, and 35 percent reported their children living with them. Fourteen percent reported that their children were infected with HIV.

Fifty-eight percent reported receiving a housing allowance (Table 63). Fifty-four percent reported having difficulty paying rent or mortgage (Table 64). Forty-nine percent reported being homeless at some time in their life (Table 65). Of those who reported being homeless, 53 percent said that it was due to their HIV status (Table 66). Housing problems related to HIV status were reported by 58 percent of the respondents (Table 67). The main housing problem mentioned by the respondents was prejudice toward persons with HIV and the high cost. Overall, 80 percent reported being satisfied with their current housing (Table 68).

Transportation Needs

With respect to transportation, 22 percent of the respondents reported always being without a ride (Table 69). Twenty-two percent reported dissatisfaction with their current means of transportation (Table 70). The main reasons for dissatisfaction were having no car and buses never being on time.

Employment Needs

When asked about their current employment status, 83 percent reported being unemployed. Of those employed, 5 percent were full-time and 11 percent were part-time (Table 71). For those who reported being unemployed: 50 percent had been unemployed approximately five years, 63 percent wanted to return to work, and 61 percent needed help in finding a job (Table 72 and 73). Fifty-four percent attributed their unemployment status to being HIV positive (Table 74). Of those who reported being employed, 61 percent expressed a need for additional training.

(Table 75).

Needed Help with Legal Problems

In assessing the need for help with legal problems, 47 percent of the respondents expressed a need for help within the past year (Table 76). Fifty-eight percent reported not obtaining the legal advice (Table 77). Of those receiving legal advice, 35 percent expressed dissatisfaction with the service (Table 78). The main reasons attributed to the dissatisfaction were lawyers' indifference, high cost of fees, and feelings of intimidation.

Services Utilized

There were approximately 30 types of services used within the past year by the respondents. The types of services mentioned included were: dental, food bank, benefits/insurance, obtaining medications, transportation, case management, support groups, vocational training, housing assistance, HALSA (legal matters), mental health, home health, drug detoxification or maintenance, inpatient medical, outpatient medical, emergency room, buddy program, community education, hospital visitation, spiritual/religious, nutritionist, homeless case management, residential drug treatment, meal preparation, LAPAN (child support), prenatal pregnancy, child care, HIV partner notification, and financial advice.

The vast majority of the respondents expressed satisfaction with the services received (93%) (Table 79). Thirty-four percent of the respondents reported that services provided needed to be culturally sensitive (Table 80). Suggestions for the improvement of services mentioned by the respondents included cultural sensitivity training, bilingual staff, greater compassion, and greater awareness of women issues. Assistance needed but not received by the respondents included dental, transportation, housing assistance, benefits counseling, and support groups. New services suggested by the respondents included a smoking cessation program, job placement, gym, home barber/beautician, veterinarian services for pets, home cleaning services, and women's studies.

HIV Testing, Counseling and Prevention

When asked about their experience with HIV testing, 57 percent reported not receiving counseling (Table 81). Of those who received counseling, the majority obtained advice on sexual behavior, and 82 percent reported that the counseling was helpful. Less than half (47%) received counseling on how to tell others about their HIV status (Table 82). Of those respondents who notified someone about their condition, the individuals they told included family (79%), partner (51%), spouses (19%), friends (75%), co-workers (31%), and a sex partner (46%) (Table 83 and 84).

Approximately 84% of those receiving HIV testing and counseling expressed satisfaction with the services obtained (Table 85). Forty-eight percent of all the respondents reported that those who administer these services should be better trained in the needs of persons with HIV (Table 86).

Preventing the transmission of the HIV was another area examined by this research. Approximately 40 percent reported having sex while intoxicated (Table 87). Thirty-seven percent reported receiving prevention education (Table 88). Over 90 percent of the respondents reported that the nature of the education concerned knowledge, attitudes, and

in crisis situations due to issues surrounding HIV disclosure of infected family members. The proposed solution was case management involving family counseling.

Providers reported that their clients encounter system problems in obtaining services. Four factors were identified: 1) clients must have an actual AIDS diagnosis in order to be eligible for services; 2) clients will lose benefits during hospitalization; 3) long-term rather than acute mental health care is needed; and, 4) there is a need for providers to coordinate care beyond the scope of their own work. The proposed solutions were to change benefit regulations as well as to manipulate the system.

Summary

Providers recommended bridge building through cultural outreach, employment, and prisons in order to improve client services. With respect to cultural outreach, they suggested establishing linkages between HIV community-based organizations (CBOs) and ethnic HIV or non-HIV CBOs. Cultural outreach was also identified as a way to reduce the isolation and loneliness of recent immigrants.

In order to build bridges through employment, it was recommended that a new model for entrepreneurship be developed among the HIV population. Job training and job sharing were recommended. Bridge building through prisons should occur through education, condom distribution, and partner notification.

Overall, the key informants felt that the quality of HIV care in Long Beach is good. However, there is a need for more coordination between HIV prevention and care services. System problems are much more difficult to surmount because of the difficulty in changing policies. Providers emphasized that their clients experience concurrent, multiple problems. Poverty is an underlying problem that makes them a fragile population vulnerable to various crises.

FOCUS GROUP DISCUSSIONS

A chief advantage of the focus group method is that it lends itself to more discussion and interaction between participants. This allows for more qualitative aspects of participants' responses to emerge since sometimes responses are less structured and do not fit into distinct categories. A strength of the focus group method is that it allows respondents to express views and opinions on particular topics in a less structured setting. Additionally, facilitators can probe for more detail and clarification.

A discussion guide consisting of a series of open-ended questions was developed for use with the focus group participants. This guide was designed to obtain qualitative data on the participant's knowledge and attitudes about prevention. Participants were also asked for their suggestions for improving prevention services in Long Beach.

Focus group discussions on prevention were conducted with six different groups. Two groups consisted of persons who engaged in substance use. One group consisted of 25 users in residential treatment. Most of this group was HIV-negative. The other group was comprised of 10 HIV-negative users who were not in residential treatment.

There were two focus groups consisting of men who have sex with men (MSM). One group consisted of 13 HIV-negative MSM from the ages of 16 to 25. The other group consisted of five

MSM who ranged in age from about 20 to 35. Four of these men were HIV-negative and one was HIV-positive.

A focus group discussion was also conducted with 13 HIV-negative youth who serve as peer health educators on high school campuses in Long Beach. The sixth group consisted of six HIV-negative women who belong to an African American church in North Long Beach.

The participants were asked to give their views on prevention and encouraged to express their views freely. The discussions were conducted at each of the group's meeting sites in order for them to feel comfortable in their own natural settings. The discussions lasted from 1 hour to 1 hour and 45 minutes.

Participants were asked if they had received prevention information and services in Long Beach during the past 3 years. A three-year period was chosen because that was when the previous needs assessment had been conducted. Participants were asked if this information resulted in a change in their knowledge, attitudes, and behavior.

Each group was co-facilitated and each facilitator took detailed notes on the discussions. Notes were then analyzed by identifying consistencies and recurrent themes as well as areas of disagreement.

Key Findings

All participants indicated that they had received prevention information. Most had received information onsite from community-based organizations that deliver HIV services in Long Beach. A substantial number had also received information from these organizations at various outreach events in Long Beach. Several participants reported that they had also received prevention information from the radio or on television.

The group of drug users in residential treatment stressed that bleach was not enough and that needle exchange is needed in Long Beach. They also felt that condoms should be made available in prison. They stated that children should be educated at young ages in schools and that parents should also educate their children.

The group of drug users outside of residential treatment stated that they always use condoms for prevention of HIV but that condoms are only one-half of prevention. They said that discussion of needles should be aired on television. Like the other group of users, they felt strongly that there should be needle exchange programs in Long Beach.

The MSM in the 16-25 year-old age group stated that although they have access to prevention information and are informed on safe behavior, they still have problems in actually practicing safer sex. They expressed concern about the relapse into unsafe behavior among MSM and felt that prevention images need to be more graphic. This group stated that they like prevention information presented on post cards because it is brief and "to-the-point". They also said that they like the phone cards with prevention messages. The group expressed the idea that parents should be targeted more with information about prevention because youths know more about prevention than they do.

The MSM in the 20-35 year-old age group stated that they too are concerned about the relapse into unsafe behavior and the practice of barebacking. They stated that public service

announcements are always late at night and are never shown during prime time. They felt that the information on billboards is too technical and that information should be more general. They favored a national slogan for prevention such as "Buckle Up." They felt that there is not enough emphasis on the relationship between testing, early intervention, and health status and outcomes.

The group of peer health educators felt that their age group needs to know that they can be tested without their parent's consent if they are 12 years old or older. They also felt that youth need more detailed information on how to use condoms. They felt that in order for prevention messages to be effective, they needed to show a young person actually living with HIV disease and be shown seroprevalence figures on youths with HIV in Long Beach. They also need a video that youth will take seriously. They felt constrained in the prevention outreach that they do in Long Beach and stated that they really should be allowed to pass out condoms and do condom demonstrations on high school campuses. They also stated that youths have to be reached in their own setting on high school campuses as they will not respond to prevention information that requires them to leave that setting.

The group of women who are members of a church stated that they received prevention information for their church's Ministerial Alliance and that this information made them more compassionate towards persons with AIDS. They felt that other churches need to address AIDS also and that the best way to reach the churches is through understanding the church's hierarchy of key figures. They expressed a need for AIDS outreach in the Long Beach City jail. They also stressed the need for women to be tested because they are at risk from male partners with prison histories and males who are unfaithful. This group stated that children and youths should be educated in private day schools, boys and girl scouts, boys and girls clubs, Sunday school classes and ROTC.

Summary

Overall, there was a substantial amount of agreement among and between the groups. Mainly the focus groups made suggestions for other populations to target and seemed more interested in proposing other populations than in talking about themselves. Substance users, MSM, and prison populations were the groups that were mentioned consistently as special populations to target with prevention. Both variables of gender and age emerged as predominant variables in the discussion. There was strong consensus that women and youths need to be targeted and reached with prevention information more than they are at present. There was also agreement that needle exchange programs should be made available in Long Beach. No opposition to needle exchange programs in Long Beach was expressed. In general, there was agreement that prevention services in Long Beach were effective.

TABLES

Table 1: Race/Ethnicity of respondents		
	Number	Percent
African American	58	20.9%
American Indian/Alaskan	6	2.2%
Asian/Pacific Islander	5	1.8%
Latino/Hispanic	55	19.9%
White/Caucasian	150	54.2%
Other	3	1.1%
Total	277	100.0%

Table 2: Primary language of respondents		
	Number	Percent
English	252	90.3%
Spanish	27	9.7%
Total	279	100.0%

Table 3: Gender of respondents		
	Number	Percent
Male	230	82.7%
Female	47	16.9%
Transgender	1	.4%
Total	278	100.0%

Table 4: Sexual orientation of respondents		
	Number	Percent
Gay/lesbian	175	64.1%
Bisexual	21	7.7%
Straight/heterosexual	77	28.2%
Total	273	100.0%

Table 5: Highest level of education		
	Number	Percent
None or Kindergarten	1	.4%
Grades 1-8	10	3.6%
Grades 9 – 11	29	10.4%
High school graduate	85	30.6%
Some college	83	29.9%
Associates degree	41	14.7%
Bachelors degree	23	8.3%
Graduate degree	6	2.2%
Total	278	100.0%

Table 6: Current annual income		
	Number	Percent
No income	13	4.8%
Under \$2,500	30	11.2%
\$2,501— \$5,000	30	11.2%
\$5,001— \$8,400	81	30.1%
\$8,401—\$9,600	48	17.8%
\$9,601 - \$11,000	11	4.1%
\$11,001 - \$15,000	23	8.6%
\$15,001 - \$20,000	18	6.7%
\$20,001 - \$30,000	11	4.1%
\$30,001 - \$50,000	4	1.5%
Total	269	100.0%

Table 7: Source of income		
	Number	Percent
Employment	50	17.9%
Social Security	53	19.0%
SSI	121	43.4%
SSDI	98	35.1%
Unemployment	98	35.1%
General Relief	18	6.5%
Private Disability Insurance	14	5.0%
Veterans Benefits	11	3.9%
Support from Relatives	11	3.9%
Other Support	20	7.2%

Table 8: Marital status		
	Number	Percent
Never Married	154	55.6%
Married	15	5.4%
Member of Unmarried Couple	37	13.4%
Separated	11	4.0%
Divorced	46	16.6%
Widowed	14	5.1%
Total	277	100.0%

Table 9: Source of HIV infection		
	Number	Percent
Unprotected sex	206	74.4%
Shared needles	21	7.6%
Both unprotected sex and sharing needles	23	8.3%
Blood transfusions	9	3.2%
Rape	2	0.7%
Unknown	10	3.6%
Other	6	2.2%
Total	277	100.0%

Table 10: Current HIV status		
	Number	Percent
Asymptomatic	96	34.9%
Symptomatic	77	28.0%
AIDS	102	37.1%
Total	275	100.0%

Table 11: Financing of medications		
	Number	Percent
Cash	3	1.6%
Insurance	182	96.3%
Family	4	2.0%
Total	189	100.0%

Table 12: Do you encounter barriers in accessing medications?		
	Number	Percent
No	163	81.1%
Yes	38	18.9%
Total	201	100.0%

Table 13: Are there side effects from these medications?		
	Number	Percent
Minimal	98	46.9%
Moderate	82	39.2%
Severe	29	13.9%
Total	209	100.0%

Table 14: Effect of medications on health condition		
	Number	Percent
Better	126	59.7%
About the Same	60	28.4%
Worse	25	11.8%
Total	211	100.0%

Table 15: Respondents experiencing chronic physical health problems		
	Number	Percent
No	142	56.6%
Yes	109	43.4%
Total	251	100.0%

Table 16: Are your chronic physical health problems HIV related?		
	Number	Percent
No	142	58.4%
Yes	101	41.6%
Total	243	100.0%

Table 17: Respondents experiencing physical health problems that need attention		
	Number	Percent
No	131	48.7%
Yes	138	51.3%
Total	269	100.0%

Table 18: Did you get the care you needed?		
	Number	Percent
No	65	34.8%
Yes	122	65.2%
Total	187	100.0%

Table 19: Do you believe you did not get the care you needed because you are HIV+?		
	Number	Percent
No	61	66.3%
Yes	31	33.7%
Total	92	100.0%

Table 20: Do you usually go to the same doctor or clinic?

	Number	Percent
No	15	5.4%
Yes	261	94.6%
Total	276	100.0%

Table 21: Where do you usually seek help for physical health problems?

	Number	Percent
Physician	178	63.8%
Emergency Room	75	26.9%
Outpatient	82	29.4%
Family and Friends	28	10.0%
Chiropractor	11	3.9%
Acupuncture	6	2.2%
Herbalist	2	.7%
Other	2	.7%
Total	279	100.0%

Table 22: Types of health insurance

	Number	Percent
Private	15	5.4%
HMO	21	7.5%
Medi-Cal	88	31.5%
Medicare	18	6.5%
MediCal/Medicare	96	34.4%
Veterans	10	3.6%
None	22	7.9%
Other	3	1.1%
ADAP	6	2.2%
Total	279	100.0%

Table 23: Number of Respondents Reporting Problems with Health Care Provider		
	Number	Percent
No	215	82.7%
Yes	45	17.3%
Total	260	100.0%

Table 24: Satisfaction with HIV health care provider		
	Number	Percent
Very Satisfied	118	42.6%
Satisfied	131	47.3%
Dissatisfied	17	6.1%
Very Dissatisfied	11	4.0%
Total	277	100.0%

Table 25: Satisfaction with general medical care (other than HIV)		
	Number	Percent
Very Satisfied	86	31.4%
Satisfied	157	57.3%
Dissatisfied	20	7.3%
Very Dissatisfied	11	4.0%
Total	274	100.0%

Table 26: Should doctors/medical staff be better trained for HIV?		
	Number	Percent
No	92	33.3%
Yes	184	66.7%
Total	276	100.0%

Table 27: Received care in a hospital within last 12 months?		
	Number	Percent
No	165	64.0%
Yes	93	36.0%
Total	258	100.0%

Table 28: Type of hospital care received		
	Number	Percent
Inpatient	32	50.0%
Outpatient	32	50.0%
Total	64	100.0

Table 29: Respondents experiencing medical care barriers due to HIV status		
	Number	Percent
No	102	87.2%
Yes	15	12.8%
Total	117	100.0%

Table 30: Rate your physical health		
	Number	Percent
Excellent	28	10.2%
Good	144	52.4%
Fair	88	32.0%
Poor	15	5.5%
Total	275	100.0%

Table 31: Compare physical health to a year ago		
	Number	Percent
Worse	40	14.4%
About the Same	159	57.2%
Better	79	28.4%
Total	278	100.0%

Table 32: Compared to others with HIV, rate your physical health		
	Number	Percent
Worse	32	11.5%
About the Same	96	34.4%
Better	151	54.1%
Total	279	100.0%

Table 33: Compared to general population, rate physical health		
	Number	Percent
Worse	71	25.7%
About the Same	137	49.6%
Better	68	24.6%
Total	276	100.0%

Table 34: Do you need help with the following:		
	Number	Percent
Getting Dressed	18	6.5%
Bathing	174	62.4%
Getting Into Bed	21	7.5%
Toileting/Hygiene	21	7.5%
Preparing Meals	65	23.3%
Household Chores	93	33.3%
Shopping/Errands	71	32.6

Table 35: Have you ever been assessed as needing psychological help?		
	Number	Percent
No	142	50.9%
Yes	137	49.1%
Total	279	100.0%

Table 36: Did you get the psychological help you needed?		
	Number	Percent
No	106	66.3%
Yes	54	33.8%
Total	160	100.0%

Table 37: Overall, rate your psychological health		
	Number	Percent
Excellent	28	10.4%
Good	115	42.6%
fair	119	44.1%
Poor	8	3.0%
Total	270	100.0%

Table 38: Compared to a year ago, how is your psychological health		
	Number	Percent
Worse	46	17.0%
About the same	119	44.1%
Better	105	38.9%
Total	270	100.0%

Table 39: Compared to others with HIV, rate your psychological health		
	Number	Percent
Worse	39	14.3%
About the same	119	43.6%
Better	115	42.1%
Total	273	100.0%

Table 40: Compared to the general population, rate your psychological health		
	Number	Percent
Worse	73	27.2%
About the Same	119	44.4%
Better	76	28.4%
Total	268	100.0%

Table 41: Do you have psychological health insurance?		
	Number	Percent
No	150	56.6%
Yes	115	43.4%
Total	265	100.0%

Table 42: If you did not get the care you needed, was it because of your HIV status?		
	Number	Percent
No	46	54.1%
Yes	39	45.9%
Total	85	100.0%

Table 43: Where do you usual obtain psychological help?		
	Number	Percent
Counselor	102	36.6%
Psychiatrist	76	27.2%
Family	54	19.4%
Friends	98	35.1%
Clergy	17	6.1%
Peer Group	63	22.6%
Other	20	7.2%

Table 44: Do you usually go to the same place for psychological help?		
	Number	Percent
No	165	60.7%
Yes	107	39.3%
Total	272	100.0%

Table 45: Satisfaction with psychological health care provider		
	Number	Percent
Very Satisfied	71	26.7%
Satisfied	150	56.4%
Dissatisfied	38	14.3%
Very Dissatisfied	7	2.6%
Total	266	100.0%

Table 46: Should psychological health care providers be better educated for HIV?

	Number	Percent
No	123	46.6%
Yes	141	53.4%
Total	264	100.0%

Table 47: Have you had any substance abuse problems needing help?

	Number	Percent
No	116	43.6%
Yes	150	56.4%
Total	266	100.0%

Table 48: Did you seek treatment for substance abuse problems?

	Number	Percent
No	131	56.2%
Yes	102	43.8%
Total	233	100.0%

Table 49: Have you participated in drug rehabilitation program?

	Number	Percent
No	96	50.5%
Yes	94	49.5%
Total	190	100.0%

Table 50: How satisfied were you with the substance abuse program?

	Number	Percent
Very Satisfied	29	29.3%
Satisfied	52	52.5%
Dissatisfied	9	9.1%
Very Dissatisfied	9	9.1%
Total	99	100.0%

Table 51: Do you have problems with teeth or gums that need help?

	Number	Percent
No	165	62.5%
Yes	99	37.5%
Total	264	100.0%

Table 52: Did you get the dental help you needed?

	Number	Percent
No	103	56.0%
Yes	81	44.0%
Total	184	100.0%

Table 53: If you did not get the care you needed, was it because of your HIV status?

	Number	Percent
No	42	48.8%
Yes	44	51.2%
Total	86	100.0%

Table 54: Do you have dental health insurance?

	Number	Percent
No	135	50.2%
Yes	134	49.8%
Total	269	100.0%

Table 55: Do you usually go to the same place for dental help?

	Number	Percent
No	169	62.8%
Yes	100	37.2%
Total	269	100.0%

Table 56: Satisfaction with dental health care provider		
	Number	Percent
Very Satisfied	63	23.6%
Satisfied	147	55.1%
Dissatisfied	42	15.7%
Very Dissatisfied	15	5.6%
Total	267	100.0%

Table 57: Should dental health care providers be better educated about HIV?		
	Number	Percent
No	125	46.1%
Yes	146	53.9%
Total	271	100.0%

Table 58: Dental health rating		
	Number	Percent
Excellent	34	13.1%
Good	91	35.0%
Fair	88	33.8%
Poor	47	18.1%
Total	260	100.0%

Table 59: Compared to a year ago, how is your dental health?		
	Number	Percent
Worse	64	24.0%
About the Same	139	52.1%
Better	64	24.0%
Total	267	100.0%

Table 60: Compared to others with HIV, rate your dental health		
	Number	Percent
Worse	33	12.7%
About the same	154	59.2%
Better	73	28.1%
Total	260	100.0%

Table 61: Compared to general population, rate your dental health		
	Number	Percent
Worse	71	26.8%
About the Same	130	49.1%
Better	64	24.2%
Total	265	100.0%

Table 62: Who do you live with?		
	Number	Percent
Alone	119	43.1%
With significant other/partner	61	22.1%
With significant other and children	19	6.9%
With spouse only	1	.4%
With spouse and children	4	1.4%
With parents	5	1.8%
With other relatives	11	4.0%
With friends	10	3.6%
With unrelated persons (renters, roommates)	17	6.2%
Residential facility	3	1.1%
Institution	8	2.9%
Homeless	1	.4%
Other	17	6.2%
Total	276	100.0%

Table 63: Are you currently receiving housing support allowance?		
	Number	Percent
No	114	41.5%
Yes	161	58.5%
Total	275	100.0%

Table 64: Do you have any difficulties paying the rent or mortgage?		
	Number	Percent
No	128	46.4%
Yes	148	53.6%
Total	275	100.0%

Table 65: Have you ever been homeless?		
	Number	Percent
No	140	51.3%
Yes	133	48.7%
Total	273	100.0%

Table 66: Were you homeless because of your HIV status?		
	Number	Percent
No	84	47.2%
Yes	94	52.8%
Total	178	100.0%

Table 67: Do you have any housing problems related to HIV status?		
	Number	Percent
No	113	42.3%
Yes	154	57.7%
Total	267	100.0%

Table 68: Satisfaction with current housing		
	Number	Percent
Very Satisfied	71	26.5%
Satisfied	142	53.0%
Dissatisfied	45	16.8%
Very Dissatisfied	10	3.7%
Total	268	100.0%

Table 69: How often are you without a ride?		
	Number	Percent
Always	58	21.6%
Sometimes	115	42.8%
Never	96	35.7%
Total	269	100.0%

Table 70: Satisfaction with current transportation		
	Number	Percent
Very Satisfied	59	21.7%
Satisfied	154	56.6%
Dissatisfied	49	18.0%
Very Dissatisfied	10	3.7%
Total	272	100.0%

Table 71: Current employment status		
	Number	Percent
Full-time	12	4.8%
Part-time	28	11.1%
Unemployed	210	83.3%
Retired	2	.8%
Total	252	100.0%

Table 72: If unemployed, are you planning to look for work?		
	Number	Percent
No	68	36.6%
Yes	118	63.4%
Total	193	100.0%

Table 73: If unemployed, do you need help finding a job?		
	Number	Percent
No	76	39.4%
Yes	117	60.6%
Total	193	100.0%

Table 74: If unemployed, is this a result of being HIV+		
	Number	Percent
No	45	46.4%
Yes	52	53.6%
Total	97	100.0%

Table 75: If employed, need job training or retraining?		
	Number	Percent
No	86	38.7%
Yes	136	61.3%
Total	222	100.0%

Table 76: Needed legal help within last year?		
	Number	Percent
No	137	52.7%
Yes	123	47.3%
Total	260	100.0%

Table 77: Did you get the legal help you needed?		
	Number	Percent
No	55	57.9%
Yes	40	42.1%
Total	95	100.0%

Table 78: Satisfaction with legal help		
	Number	Percent
Very Satisfied	13	15.9%
Satisfied	40	48.8%
Dissatisfied	24	29.3%
Very Dissatisfied	5	6.1%
Total	82	100.0%

Table 79: Satisfaction with services received		
	Number	Percent
Very Satisfied	88	33.6%
Satisfied	155	59.2%
Dissatisfied	15	5.7%
Very Dissatisfied	1	.4%
Total	259	100.0%

Table 80: Are HIV services culturally sensitive?		
	Number	Percent
No	161	66.0%
Yes	83	34.0%
Total	244	100.0%

Table 81: When tested for HIV, did you receive counseling?		
	Number	Percent
No	144	56.9%
Yes	109	43.1%
Total	253	100.0%

Table 82: Have you received counseling about telling others about HIV status?		
	Number	Percent
No	132	52.8%
Yes	118	47.2%
Total	250	100.0%

Table 83: Have you told other people about HIV status?		
	Number	Percent
No	9	3.3%
Yes	261	96.7%
Total	270	100.0%

Table 84: Who have you told about your HIV status?		
	Number	Percent
Partner	143	51.3%
Family	220	78.9%
Spouse	53	19.0%
Friend	210	75.3%
Co-Worker	87	31.2%
Sex Partner	129	46.2%

Table 85: Level of satisfaction with testing and counseling services received		
	Number	Percent
Very Satisfied	59	23.1%
Satisfied	160	62.0%
Dissatisfied	17	6.6%
Very Dissatisfied	19	7.4%
Total	255	100.0%

Table 86: Should testing and counseling staff be better trained?		
	Number	Percent
No	139	52.5%
Yes	126	47.5%
Total	265	100.0%

Table 87: How often have sex while intoxicated		
	Number	Percent
Always	6	3.0%
Sometimes	75	37.1%
Never	121	59.9%
Total	202	100.0%

Table 88: Received prevention education?		
	Number	Percent
No	161	63.4%
Yes	93	36.6%
Total	254	100.0%

Table 89: Are there times when you smoke cigarettes?		
	Number	Percent
Always	98	35.9%
Sometimes	66	24.2%
Never	109	39.9%
Total	273	100.0%

Table 90: Are there times when you have unprotected sex?		
	Number	Percent
Always	12	4.4%
Sometimes	82	30.4%
Never	176	65.2%
Total	270	100.0%

Table 91: Are there times when you share needles?		
	Number	Percent
Sometimes	28	10.3%
Never	243	89.7%
Total	271	100.0%

Table 92: Are there times when you use street drugs?		
	Number	Percent
Always	5	1.8%
Sometimes	65	24.0%
Never	201	74.2%
Total	271	100.0%

FOCUS GROUP QUESTIONS

1. Have you received information about HIV prevention within the last 3 years?
 - a. If yes, where & when?
 - b. Describe the information you received. (Print or electronic media, population groups, risk reduction messages, testing services)
2. Did the information result in changes in your:
 - a. knowledge about HIV and methods to prevent its spread?
 - b. attitudes about HIV and methods to prevent its spread?
 - c. behavior relative to HIV and methods to prevent its spread?
3. Was the information you received useful to you?
4. Did you find this information effective in reducing the spread of HIV?
5. Did you share any of this information with friends or family members?
6. If you could tell health educators how to be more effective in reducing the spread of HIV, what would you suggest?
7. Is there anything else you would like to share?

[If no,]

- Would you have been interested in receiving information?
- What information would you be interested in receiving? (Print or electronic media, population groups, risk reduction messages, testing services)

PROVIDER QUESTIONS

Introduction: I am working on a needs assessment study of HIV-infected clients who seek services in Long Beach. The study is being conducted for the Long Beach Comprehensive HIV Planning Group. As part of the study, we are interviewing service providers.

You may have already received a questionnaire which is being faxed to you by the Health Department. I'd like to ask the following questions about your agency:

Name of Agency:

Name of Individual Provider:

What are your goals and objective?

What population(s) do you serve?

What types of services do you provide?

How long have you been providing these services?

What is your staffing breakdown?

Number of paid staff:

Number of volunteer staff:

What are the major problems you've encountered in delivering services?

What solutions have you developed? How have you implemented these solutions?

What are your funding priorities?

Is there anything else you would like to add?
